STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE – ADMINISTRATIVE HEARING BUREAU

APPEAL TO INSURANCE COMMISSIONER

PURPOSE OF THIS FORM: Use this form to file an appeal with the CDI's Administrative Hearing Bureau (AHB) from a written decision of an insurer or the Workers' Compensation Insurance Rating Bureau (WCIRB) in response to requests for review, requests for policyholder information, and requests for reconsideration (Complaint and Request for Action) provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b). Procedural requirements for appeals governed by these Insurance Code sections are found in California Code of Regulations, title 10, sections 2509.40 et seq.

APPELLANT (Person or business appealing final decision of insurance carrier or WCIRB)

1. Full name: _____
2. Mailing address: _____
3. Telephone No.: _____
4. Facsimile No.: _____
5. Email address: _____
6. Name of Appellant's representative (if applicable): _____
7. Representative's mailing address: _____
8. Representative's telephone number: _____
9. Representative's Facsimile number: _____
10. Representative's email address: _____
11. Insurance Policy Number(s) underlying the dispute: _____
12. Named Insured: _____
13. Policy Periods impacted by the dispute (mm/dd/year) to (mm/dd/year): _____

RESPONDENT (Entity whose final decision you are appealing)

(Check one or more boxes) **INSURANCE COMPANY** ☐ **WCIRB** ☐

14. If you checked the box for Insurance Company, provide the name of the company: _____
15. The name and/or address of Respondent's designated person for the receipt of Appeals: _____
16. Telephone number: _____
17. Facsimile number: _____

PRELIMINARY INFORMATION

18. Have you filed a Complaint and Request for Action with your insurance carrier or the WCIRB about the dispute?

    Yes ☐ No ☐

DO NOT COMPLETE THIS FORM IF YOUR ANSWER TO QUESTION 18 IS - NO -.

19. Date and to whom you submitted a Complaint and Request for Action: _____

20. Have you received a written final decision from the insurance carrier or the WCIRB on your Complaint and Request for Action?

    Yes ☐ No ☐

If your answer to question 20 is YES, you must include 2 copies of the following documents with your appeal.

1. a copy of your Complaint and Request for Action.
2. a copy of the final written decision by the insurance company or the WCIRB on your Complaint and Request for Action.

21. Have you previously contacted other departments within the Department of Insurance (e.g. CDI's Consumer Hotline, CDI's Consumer Services Division, CDI's Ombudsman,) regarding the same dispute underlying the appeal?

    Yes ☐ No ☐

If your answer to question 21 is YES, answer questions 22 – 26:

22. Name of CDI Department and/or CDI personnel contacted: _____

23. Date(s) contacted CD: _____

24. Action, if any, taken by CDI (e.g. file opened, letter sent, advice given): _____

25. CDI File No: (if any) _____

26. Attach to the appeal a copy of any correspondence you received form the CDI Department**.**

STATEMENT OF APPEAL

Please identify the nature of the dispute on appeal. (For example: My insurance carrier assigned the wrong classification to my policy or the WCIRB incorrectly calculated my experience modification.). Then provide a complete and concise statement as to why the Appellant believes the insurance carrier's or WCIRB's written decision on your Complaint and Request for Action is wrong. Remember to attach all supporting documentation required in California Code of Regulations, title 10, section 2509.47.

Signature: _____

Name: _____ **Date:** _____

Title: _____